Blue Cross
Blue Shield
of Rhode Island

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November 15, 2007

Mr. Christopher Koller
Health Insurance Commissioner
233 Richmond Street
Providence, Rhode Island 02903-4233

RE: Filing of Subscription Rates for Class DIR

Dear Mr. Koller:

This letter, together with the actuarial schedules enclosed, comprises a filing of subscription rates by Blue Cross & Blue Shield of Rhode Island ("Blue Cross") for direct pay subscribers in Class DIR Basic (Pool I) and Preferred (Pool II) programs. This filing includes proposed rates to become effective April 1, 2008.

The rates proposed in this filing will affect the approximately 14,000 members enrolled as of October 2007 in Class DIR.

**Definition of Class DIR**

Class DIR is the rating classification for persons not eligible for employer-based (other than as a self employed individual), nor State or Federal programs. Enrollment is on a non-group basis either through direct application to the Plan or through conversion from prior group coverage. Two rating pools are employed in the Class -- the Basic Pool (Pool I) utilizing community rates and the Preferred Pool (Pool II) with rates determined based on the age and gender of the subscriber. Group conversions occur monthly and an annual open enrollment period is conducted for the Basic Pool (Pool I), while enrollment in the Preferred Pool (Pool II) is available continuously throughout the year for applicants passing a health screening.

**Benefit Changes Effective With This Filing**

At this time, Blue Cross requests to introduce the following modifications to our products. First, we have designated the HealthMate Coast-to-Coast Direct Plan 2000/4000 as a Wellness Health Benefit Plan pursuant to R.I. Gen. Laws § 27-18.5-9. Members enrolled in the HealthMate Coast-to-Coast Direct Plan 2000/4000 will receive a monetary reward equal to 10% of their annual paid premium for compliance with the wellness reward requirements. Also, we intend to introduce a specialty pharmacy network and a $75 copayment for specialty drugs on our HealthMate Coast-to-Coast Direct Plans 400/800 and 2000/4000. More details are provided in the testimony of Mr. Boyd. The benefits for the HealthMate for HSA Direct Plans 3000/6000 and 5000/10000 will not change. If approved, the following Class DIR products will be available:

- *HealthMate Coast-to-Coast Direct Plan 400/800:* Includes a $400 per individual/$800 per family deductible, 10% member paid coinsurance in-network for hospitalization, lab tests,

and x-rays, $20 PCP/$40 Specialist co-payments for in-network services (no deductible), and member paid coinsurance of 20% generic/25% brand/50% non-preferred and $75 specialty prescription drugs at participating pharmacies. Pharmacy coverage does not apply toward the deductible. The plan includes an in-network out of pocket maximum of $2,500 per individual / $5,000 per family. In general, member cost share is greater at out-of-network providers.

- *HealthMate Coast-to-Coast Direct Plan 2000/4000:* This plan is comparable to HealthMate Direct 400/800. The only differences are the deductible, coinsurance percentages, and out of pocket maximums. The deductible is $2,000 per individual / $4,000 per family under HealthMate Direct 2000/4000, and the member paid coinsurance is 20% for in-network benefits. The out of pocket maximums for the HealthMate Coast-to-Coast Direct Plan 2000/4000 are $3,000 and $6,000 for individual and family respectively for in-network services. Pharmacy coverage does not apply toward the deductible. Members will have the option of engaging in the Wellness Reward Program and may receive a monetary reward of 10% of annual paid premiums if all the requirements of the program are met.

- *HealthMate for HSA Direct Plan 3000/6000:* The HealthMate for HSA Direct Plan 3000/6000 includes deductibles of $3,000 per individual / $6,000 per family. These deductibles apply to all covered services except certain preventive care services. Prescription drug coverage is applied toward the deductible. After satisfaction of the deductible, in-network benefits are paid at 100% for all covered services. In general, member cost share is greater at out-of-network providers.

- *HealthMate for HSA Direct Plan 5000/10000:* The HealthMate for HSA Direct Plan 5000/10000 is comparable to HealthMate for HSA Direct Plan 3000/6000. The only difference is the amount of the deductibles. The deductibles are $5,000 per individual / $10,000 per family. These deductibles apply to all covered services except certain preventive care services. Prescription drug coverage is applied toward the deductible. After satisfaction of the deductible, in-network benefits are paid at 100% for all covered services. In general, member cost share is greater at out-of-network providers.

**Required Rates**

Blue Cross last filed rate changes for its Class DIR subscribers on November 20, 2006 for an effective date of April 1, 2007. The Office of the Health Insurance Commissioner (OHIC) approved this rate filing with modifications on February 21, 2007. The overall average rate increase approved with that filing, exclusive of any Premium Assistance amounts, was 4.0%.

The overall average required rate increase projected in this filing, exclusive of any Premium Assistance amounts, is 12.7%. The proposed rate increases for Basic (Pool I) and Preferred (Pool II) are 15.0% and 8.0%, respectively. All rates included in this filing will remain in effect for the twelve-month period commencing April 1, 2008. The Class DIR Basic (Pool I) required monthly rates and the Preferred (Pool II) required monthly rates for the four Direct Pay products are included in the following table:

## Required Basic (Pool I) Monthly Rates

| | | HM 400 | HM 2000 | HM for HSA 3000 | HM for HSA 5000 |
|---|---|---|---|---|---|
| Under 65 | Individual | $684.67 | $514.55 | $440.97 | $348.41 |
| | Family | $1,294.77 | $974.29 | $835.67 | $661.28 |
| 65 and over | Individual | $1,074.81 | $807.27 | $691.55 | $545.97 |
| | Family | $2,033.34 | $1,528.43 | $1,310.04 | $1,035.29 |

## Required Preferred (Pool II) Monthly Rates

| | | HM 400 | HM 2000 | HM for HSA 3000 | HM for HSA 5000 |
|---|---|---|---|---|---|
| Under 25 | Male | $193.57 | $146.09 | $125.56 | $99.72 |
| | Female | $269.29 | $202.91 | $174.20 | $138.07 |
| | Family | $648.45 | $489.37 | $420.57 | $333.99 |
| 25-29 | Male | $213.74 | $161.22 | $138.51 | $109.93 |
| | Female | $304.69 | $229.46 | $196.93 | $155.99 |
| | Family | $725.00 | $546.80 | $469.74 | $372.76 |
| 30-34 | Male | $242.96 | $183.14 | $157.28 | $124.73 |
| | Female | $361.48 | $272.07 | $233.41 | $184.75 |
| | Family | $768.21 | $579.22 | $497.49 | $394.64 |
| 35-39 | Male | $277.53 | $209.08 | $179.48 | $142.23 |
| | Female | $358.60 | $269.91 | $231.56 | $183.29 |
| | Family | $810.19 | $610.71 | $524.45 | $415.89 |
| 40-44 | Male | $296.46 | $223.28 | $191.64 | $151.82 |
| | Female | $391.93 | $294.92 | $252.97 | $200.17 |
| | Family | $827.89 | $623.99 | $535.82 | $424.86 |
| 45-49 | Male | $357.78 | $269.29 | $231.03 | $182.87 |
| | Female | $433.91 | $326.41 | $279.93 | $221.43 |
| | Family | $871.92 | $657.03 | $564.10 | $447.15 |
| 50-54 | Male | $452.43 | $340.31 | $291.82 | $230.80 |
| | Female | $506.34 | $380.76 | $326.45 | $258.10 |
| | Family | $969.87 | $730.52 | $627.01 | $496.75 |
| 55-59 | Male | $578.77 | $435.10 | $372.97 | $294.78 |
| | Female | $577.54 | $434.17 | $372.18 | $294.16 |
| | Family | $1,084.27 | $816.35 | $700.50 | $554.69 |
| 60-64 | Male | $618.69 | $465.05 | $398.61 | $315.00 |
| | Female | $618.69 | $465.05 | $398.61 | $315.00 |
| | Family | $1,177.28 | $886.14 | $760.24 | $601.79 |

**Filing Schedules**
Schedules displaying the required rates and detailed actuarial schedules documenting the calculation of the required rates are enclosed as Schedules 1 through 58. Schedule 53 pertains to the Hospital, Surgical/Medical, and Preferred Rx claims projections, and is being submitted confidentially under separate cover.

The underlying actuarial methodology used in the preparation of the required rates in this filing is similar in nature to the previous Class DIR rate filing submitted to the OHIC. The filing schedules and supporting actuarial pre-filed testimony detail the rating methodology.

**Medical Loss Ratio**
In the 2007 Class DIR rate filing, the Recommendation of the Hearing Officer (HIC No. 06-RH-01), as adopted by the Order and Decision of the Health Insurance Commissioner on February 21, 2007, stated as follows on page 34:

> "Going forward, the rating process should be modified to establish a target loss ratio for Pool II at approximately 70%, with adjustments to that benchmark as deemed necessary or appropriate by Blue Cross. Such a modification is within the proper conduct of Blue Cross's business and in the public interest. It also protects consumer interests and advances the welfare of the public."

As further described in my pre-filed testimony, Blue Cross has not modified the rating process to establish a target loss ratio for Pool II of 70% as we did not find such a loss ratio to be consistent with the proper conduct of our business or in the best interest of the public. Imposition of a 70% loss ratio would have the effect of dramatically increasing Pool I rates.

**Pre-Filed Testimony**
Contemporaneous with this filing, we are submitting separately the pre-filed testimony of Thomas Boyd, Executive Vice President, who will be Blue Cross' policy witness, Augustine Manocchia, MD, Chief Medical Officer, who will be Blue Cross' witness with regards to medical management issues, and myself, who will be Blue Cross' actuarial witness at the upcoming rate hearing on this matter. We believe submitting the pre-filed testimony contemporaneously with the rate filing will make the discovery process more efficient and decrease the length of time of all aspects of the hearing process.

**Affordability as Addressed in the Rate Filing**
In consideration of previous rate decisions issued by the OHIC, Blue Cross has taken many steps to address the issue of affordability in this rate filing. Specifics of these programs are detailed in the pre-filed testimonies of Mr. Boyd and Dr. Manocchia.

**Stability of the Direct Pay Market**

Over the last several years the Direct Pay market in Rhode Island has been stable with enrollment being fairly steady. In a period with uninsured rates rising around the country and the shrinking of group benefits, Blue Cross is of the view that compared to other states we have successfully maintained the delicate balance between financial viability and the need to have cross-subsidies within Direct Pay rates. These cross-subsidies are an important component in maintaining a balance between affordability for the members paying the subsidized rate and attractiveness for the members paying the rates which are doing the subsidizing. Specifically three main cross-subsidies are built into the rates. These cross-subsidies have been in place in the Direct Pay rates for many years. They are for various ages, with the younger population subsidizing the older population; various plans, with the richer benefit plans being subsidized by the not-as-rich plans; and pools, with the Preferred Pool II subsidizing the Basic Pool I. We foresee being able to maintain this balance provided that no major marketplace disruptions occur. One such disruption might be the introduction of another carrier into the Individual Market where such carrier adopts different rating rules and pricing strategies than are currently in place. A dramatic difference in rating rules and pricing strategies between carriers will have the result of destabilizing this market by disrupting the balance of the cross-subsidies inherent in our rates. Utilizing different rating rules and pricing strategies would advantage a new carrier on younger and medically underwritten individuals, smaller family size, and plans offering fewer benefits; yet would disadvantage a new carrier on guaranteed issue business. This could destroy the delicate pricing structure that is currently in place and could have significant adverse effects on the viability of the Direct Pay market.

**Conclusion**

The development of the actuarial assumptions has been developed by my staff and reviewed by myself. I certify that this rate filing was developed utilizing sound actuarial assumptions and methodologies.

In accordance with the filing fee requirements contained in section 42-14-18 of the General Laws of Rhode Island, a filing fee of $100 ($25 per each policy) has been included with this submission via electronic funds transfer (EFT). This filing pertains to the following policy form numbers which have been submitted to the Department under separate cover:

- Form Number HMC2C DIRECT 400/800 (04/08)
- Form Number HMC2C DIRECT 2000/4000 (04/08)
- Form Number HM HSA DIRECT 3000/6000 (04/08)
- Form Number HM HSA DIRECT 5000/10000 (04/08)

We respectfully ask for your timely approval of this filing as submitted. Blue Cross and Blue Shield of Rhode Island believes that the proposed rates are in the interest of both the public and the Corporation.

As always, we shall be pleased to provide any additional information that you, or the OHIC's staff and consulting actuary, may require.

Sincerely,

John Lynch, F.S.A., M.A.A.A.
Chief Actuary

JL/swl

Enclosures

cc: Mr. G. Rollin Bartlett, FLMI, CLU, CHFC, CIE
Mr. Normand G. Benoit, Esquire
Mr. John A. Cogan, Jr., Esquire
Mr. Charles C. DeWeese, F.S.A., M.A.A.A.
Dr. Augustine Manocchia
Ms. Genevieve M. Martin, Esquire
Ms. Monica Neronha
Mr. James E. Purcell
Mr. Thomas Boyd
Mr. James Joy